Massachusetts Patient-Centered Medical Home Initiative Council

Framework for Design and Implementation

November 2009

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I. Introduction

In June 2009, Secretary Judyann Bigby, of the Massachusetts Executive Office of Health and Human Services (EOHHS) invited a large group of consumer, physician, nurse practitioner, hospital, insurer, state agency and other interested stakeholder representatives to form the Council of the Massachusetts Patient-Centered Medical Home Initiative (PCMHI). The purpose of the PCMHI was defined in that invitation as "to sustain health reform in Massachusetts and assure a high-performing health system" through a cooperative effort "to assure access to high quality, enhanced primary care." The purpose of the Council is to advise EOHHS in its role as convener and overseer of the PCMHI.

The Patient-Centered Medical Home Initiative Council (Council) met seven times between June and October 2009 to develop a framework for the PCMHI to enable a smaller steering committee to subsequently develop more detailed plans, ultimately leading to the implementation of the Initiative in the late spring of 2010. The Council focused its efforts on developing a framework for a multi-payer Patient-Centered Medical Home (PCMH) effort involving all the major Massachusetts commercial and Medicaid payers, and a diverse group of Massachusetts primary care practices.

The PCMH concept includes both the transformation of primary care practice and supplemental and modified payments to practices. The need for transformation was called for by the Institute of Medicine in 2001 when it wrote that if problems in care delivery are due to care system design, improvements in care "cannot be achieved by further stressing current systems of care. The current systems cannot do the job. Trying harder will not work. Changing systems of care will."[1] Several years later, the American Academy of Family Practice, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association called for a specific approach to transforming primary care with the release of the "Joint Principles of the Patient-Centered Medical Home."[2]

The PCMHI is intended to address a series of problems including:

- fragmented, discontinuous care that harms patient health status and increases costs;
- increasing prevalence of chronic disease, and suboptimal management of chronic disease among patients with such illness; and
- a growing shortage of primary care providers.

The PCMH concept is rooted in the early work of the American Academy of Pediatrics on medical homes for children with special health care needs and in Dr. Ed Wagner's heavily evaluated Chronic Care Model, which focuses on transforming primary care

[1] Crossing the Quality Chasm: A New Health System for the Twenty-first Century. Institute of Medicine Washington, National Academy Press, 2001.
[2] www.medicalhomeinfo.org/Joint%20Statement.pdf. Accessed September 23, 2009.

practices to provide more effective care to patients with chronic conditions.[3] It is a dynamic concept that is likely to continue to evolve, even while, and perhaps as a result of, national activity to implement and test the concept.[4]

As of late 2009, in almost every state there is a payer-provider PCMH initiative of some form being designed or already implemented. The Council considered this experience and early research findings regarding the PCMH to design the framework of an initiative specifically for Massachusetts. This document describes the framework that the Council developed and recommended as a product of its initial seven meetings.

II. Objectives and Framework for the PCMHI

The Council began its work by affirming the objectives contained in Secretary Bigby's initial letter to the Council members, and expanding on them. The Council advised the adoption of the following PCMHI objectives:

1. to implement and evaluate the PCMH model as a means to achieve accessible, high quality primary care;
2. to demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model, and
3. to attract and retain primary care clinicians into practice in Massachusetts by increasing resources available to practices and improving their quality of work life.

The Council identified the following desired outcomes for the practices initially participating in the PCMHI:

- mastery of 12 practice redesign core competencies (described below);
- measurable improvement in patient experience, access to care, evidence-based care delivery, and clinical outcomes relative to non-participating practices, and
- reductions in medical cost trend relative to non-participating practices.

Council members agreed that the PCMHI was not an experiment, but rather a long-term commitment to a change that Massachusetts could not afford to fail to implement successfully. The Council advised that the implementation timeline with the initial participating practices should be for more than one year to ensure robust results, but did not agree upon a specific desired duration.

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[3] Wagner EH, Austin B, and Von Korff M, "Improving Outcomes in Chronic Illness," *Managed Care Quarterly* 4, no. 2 (1996): 12–25 and Wagner EH, Austin B, and Von Korff M, "Organizing Care for Patients with Chronic Illness," *Milbank Quarterly* 74, no. 4 (1996): 1–34

[4] The Chronic Care Model (CCM) and PCMH share much in common, including population-based care management supported by use of information systems, and a proactive, team-based approach to patient-centered care. The PCMH focuses on primary care for all patients (not just those with chronic illnesses), and tends to be physician-centric (although does not have to be). The CCM also focuses on patient self-management and the mobilization of community resources to meet the needs of patients. Less emphasized by the CCM are around-the-clock access to services and patient-centered concepts, such as caregiver cultural competence.

As a starting point for developing a framework for the PCMHI, the Council was asked to comment on the content of four "pillars" around which to organize the Initiative:

A. Practice Redesign
B. Consumer Engagement
C. Incentive Alignment
D. Evaluation

This document presents the recommended framework for the first four pillars and adds the following four additional concepts based on the advice of the Council:

E. Practice Engagement
F. Payer Participation
G. Role of the Executive Office of Health and Human Services
H. Timeframe

A. Practice Redesign

The Council recommended that for the PCMHI to succeed, attention needed to be focused on the transformation of primary care practices for the delivery of both primary and secondary prevention services and management of chronic conditions. The Council provided extensive advice regarding the core competencies that the participating practices should demonstrate following their participation in the PCMHI, recognizing that some practices currently possess more than others. The Council specifically advised that a practice should possess the following core competencies in order to be recognized as a PCMH:

1. Patient/family-centeredness[5]: This means that longitudinal care is delivered with transparency, individualization, recognition, respect, linguistic and cultural competence, and dignity.[6] Such care also provides patients/families/caregivers with choice in all matters and possesses an ongoing focus on consumer service, with bi-directional feedback.
2. Multi-disciplinary team-based approach to care: This is a less physician-centric hierarchical model for care delivery than is found in traditional primary care practice and is one that requires effective team communication, collaboration and role definition.
3. Planned visits and follow-up care: In contrast to episodic, reactive care, this manner of primary care delivery tracks patients on an ongoing basis so that the practice is informed and ready to address the patient's needs holistically

[5] "Patient/family/caregiver" recognizes that in pediatric care and in care for some adults, family members and caregivers play a primary role in identifying and communicating the health needs of a patient and in self-management activities.
[6] Berwick DM. "What 'Patient-centered' Should Mean: Confessions of An Extremist". *Health Affairs* 28, no. 4, w555-565, published online May 19, 2009.

whenever the patient makes contact, and follows up with patients after encounters, as necessary.

4. Population-based tracking and analysis with patient-specific reminders: To support planned visits and follow-up care, a practice needs information tracking capacity in the form of a freestanding or Electronic Health Record (EHR) based patient registry with reporting functionality.
5. Care coordination[7] across settings, including referral and transition management: Practices assume responsibility for tracking and assisting patients as they move across care settings, and for coordinating services with other service providers including behavioral health and social service providers.
6. Integrated care management focused on high-risk patients: For the most clinically at-risk patients in a practice, a care manager is either a) based in the practice or b) residing outside of the practice but otherwise tightly integrated with the practice team.
7. Patient and family education: The practice team educates patients and family members both on primary preventive care, and on self-management of chronic illness (i.e., secondary preventive care).
8. Self-management support by all members of the practice team: Extending beyond education, self-management support assists the patient and/or family/caregiver with the challenges of ongoing self-management, directly and/or through referral.
9. Involvement of the patient in goal setting, action planning, problem solving and follow-up: Patient-centered primary care requires care planning and related activities focused on a patient's specific circumstances, wishes and needs.
10. Evidence-based care delivery, including stepped care protocols: Care should be evidence-based wherever evidence exists, and follow stepped protocols for treatment of illness.
11. Integration of quality improvement strategies and techniques: Practices should utilize the improvement model emphasized by the Institute for Healthcare Improvement to measure performance, identify opportunities for improvement, test interventions, and reassess performance.
12. Enhanced access: Another hallmark of patient-centered primary care is the availability of easy and flexible access to the primary care team, including alternatives to face-to-face visits, such as e-mail and telephone[8].

Primary care practices face significant challenges to develop and demonstrate these core competencies. The Council advised that practices will require technical support and infrastructure development to successfully implement and master them. The Council further recommended the adoption of the following strategies to facilitate practice redesign among the PCMHI participating practices:

[7] See Attachment A for the Council's endorsed complete definitions of "care coordination" and "care management."

[8] Other use of technology, such as to improve medication compliance and provide remote behavior coaching, represents additional means for enhancing access.

1. Learning collaborative: This is a one-to-two year effort that brings together participating primary care practice teams to learn from faculty using a structured syllabus, and to learn from each other through sharing of experience.
2. Continuing education courses: To supplement the learning collaborative and to help clinicians meet continuing education requirements, the MassAHEC Network could offer courses on the core competencies.
3. Practice coaching: Practice coaches assist practice teams before and after learning collaborative sessions and provide both quality improvement assistance and technical direction on practice redesign and transformation.
4. Patient registry: A patient registry allows a practice to track patients for the purposes of maintaining a history of clinical values, for indicating when a patient may be due for a service, and to examine practice performance caring for like groups of patients.
5. Frequent narrative and data reports from practices and written feedback from coaches: Practices submit narrative and quantitative data monthly and receive written feedback and suggestions from a practice coach.
6. Development of relationships with hospitals in order to receive timely notification of patient hospital admission, discharge and Emergency Room (ER) use: It is difficult for primary care practices to effectively perform the care management function with high-risk patients without their receipt of timely notification of hospital admission and discharge and of ER use.
7. Provision of timely, actionable data from payers and pharmacy benefit managers: While not viewed by practices to be of the same value as real-time notification of hospitalization and ER use, retrospective data can enable practices to benchmark and identify subpopulations in need of intervention, such as high risk patients, and patients who are not adhering to chronic illness medication regimens and are frequent users of ER services. Such data can also support medication reconciliation.[9]
8. Provision of registry data trends and benchmarks: Because participating practices are expected to report data from their patient registries to a common repository, the practices have the opportunity to benefit from cross-practice registry trend and benchmark data.
9. Web site with support for social networking: Communication among practices, and from learning collaborative faculty and practice coaches to practices, can be strengthened through a web site or listserv.
10. Patient and family education: Practice teams may find patients and families/caregivers better able to engage as partners if consumers are educated regarding the medical home and the roles of both providers and patients. To promote the patient's role as a partner in health care, practices will provide training and tools to enhance their patients' self-management skills.

The Council further advised that some core competencies lend themselves to disease-specific changes (e.g., self-management support), while others require practice-wide change (e.g., patient-centeredness). For those core competencies requiring condition-

[9] For practices with e-prescribing systems within or independent of an EMR, real time data can be provided to help inform decision making at the point of service.

specific changes, the Council recommended adoption of the idea that initial technical support would focus on a limited number of common conditions for the practices, with the pediatric practices likely to focus on a different condition(s) than primary care practices treating an adult population. The Council advised of the need to assure that transformation for *all* patients eventually occurs, and that the technical support will result in change for the entire practice. The specific clinical focus recommendations are as follows:

The clinical focus detailed below would be applicable in Year 1 of the PCMHI. Experience has shown that providers learn the new care model quickest if there is an initial focus on a specific disease or condition. Once the new processes are learned and in place, providers are in a position to spread the care model more broadly.

Adult Population:

- *Condition focus*: people with diabetes, including their co-morbidities
- *Spread in Year 1*: once the practices have grasped the new care processes working with patients with diabetes, move quickly to include in the population of focus all high-risk patients, regardless of disease or condition
- *Preventive care*: incorporate prevention services into planned care for the above two targeted populations, focusing on mammography, colon cancer screening, Pap smears, and flu shots

Pediatric Population:

- *Condition focus*: patients with asthma and Attention Deficit Hyperactivity Disorder (ADHD), including their co-morbidities
- *Spread in Year 1*: once the practices have grasped the new care processes working with patients with asthma and ADHD, include all high-risk patients regardless of disease or condition
- *Preventive care*: focus on obesity prevention among children at–risk for obesity, and specified preventive services (i.e., well-child visits, adolescent well visits and vaccinations) for children with asthma, ADHD or at risk for obesity.

The Council advised that practices that participate in the PCMHI should be subject to external review to confirm the extent to which they are operating as medical homes. The National Committee for Quality Assurance (NCQA) PCMH recognition program has been used elsewhere and was considered but not endorsed. The Council felt that the Steering Committee should consider external review options as it develops participation details for recommendation to the Council.

Finally the Council recommended that the technical support provided to practices must:

- tailor some of the transformation support strategies for small practices, and
- include a focus on both primary and secondary prevention services.

EOHHS, in collaboration with the University of Massachusetts Medical School's Department of Commonwealth Medicine and Bailit Health Purchasing, will be providing the learning collaborative sessions, the practice coaches, the web-based learning courses and an optional patient registry for practices that do not have EMRs.

The Council noted that it will be important to coordinate information technology-related practice redesign efforts with the state and national initiatives to promote the increased use of EMRs, including the pending publication by the Massachusetts eHealth Institute of a program to implement EMRs statewide. The Council also took note of the likely resource strain for any practice attempting to implement the PCMH and an EMR simultaneously.

B. Consumer Engagement

An important PCMH concept, derived from the Chronic Care Model, is that a prepared, proactive practice team productively interacts with an informed, activated patient who is participating in the management of his/her care as much as is possible.[10] Council members discussed the limited attention given to informing and activating patients and families/caregivers in other PCMH initiatives across the U.S., and recommended considerable focus on the area in Massachusetts.

Council members advised that efforts at consumer engagement need to occur both in the practice setting and in the community, outside of the practice setting. While the Council did not recommend specific strategies to be pursued, it did identify potential strategies within each category:

a. Within the Primary Care Practice Setting

1. Educate consumers, including consumers from different cultural groups, on their roles and responsibilities in a medical home.
    - Create culturally relevant and understandable patient education and marketing materials about the medical home concept and the patient's role and responsibilities.
    - Educate community health workers, patient navigators, medical interpreters, and community-based organizations about the medical home concept so that they can help reinforce the patient's understanding and active role.
    - Provide patient education sessions for health literacy to improve patient/provider communication, promote patient empowerment and raise patient activation levels.
2. Involve consumers in practice redesign to assure patient-centeredness.
    - Invite consumers to participate in focus groups or advisory groups that assist practice teams to understand the consumer perspective on patient-centeredness.
    - Utilize patients and family members as faculty at learning collaborative sessions.

[10] Consumer engagement is a term also used to refer to insurance benefit designs that encourage patients to use health care services more effectively. Creating new benefit designs is beyond the scope of this initiative.

b. Beyond the Primary Care Practice Setting

1. Create practice linkages to community-based resources, including both other medical service providers (e.g., specialists, hospitals, home health agencies and non-agency-based resources) and caregiver supports, including family-based resources:
    - Vet all resources identified for consistency with PCMH goals of being patient-centered and empowering.
    - Utilize the planned learning collaborative website to list all available resources identified above, organized by location. The principal users of the website would be participating practice teams, but a public consumer option could also be considered.
    - Include best practice sharing during monthly learning collaborative conference calls with participating practices.
2. Identify or develop community-based peer[11] support programs, such as:
    - The Department of Public Health (DPH) program in Chronic Disease Self-management Skill Development; and other DPH programs, such as the DPH Initiative for Children with Special Health Care Needs
    - community-based disease-specific self-management skill development programs, and
    - web-based self-management skill development programs.
3. Identify or develop community-based wellness and lifestyle support programs, as follows:
    - Research healthy community programs on the *Mass in Motion* website (www.mass.gov/massinmotion/).
    - Outreach to the following to obtain program and resource information:
        - city and town administrators;
        - community non-profit human service organizations;
        - ethnic and cultural organizations;
        - houses of worship;
        - public and private schools, and
        - community hospitals.
4. Identify employer-based wellness and lifestyle support programs by:
    - contacting trade organizations such as Associated Industries of Massachusetts, the Massachusetts Business Roundtable, and the Chambers of Commerce to identify key employers within the communities of participating practices, and
    - contacting employer human resource departments within the communities of participating practices to obtain program information.
5. Identify or develop payer and employer consumer incentive programs by:
    - surveying all participating payers regarding consumer incentive programs;
    - surveying employers identified above for consumer incentive programs, and

[11] "Peer" refers to another patient or family member of a patient with one or more similar characteristics to that of the patient or family member.

- encouraging payer and employer incentive programs and benefit designs that are supportive of self-management of chronic conditions.

The Council created a Consumer Engagement Work Group to develop specific strategic recommendations for adoption as part of the PCMHI. The Work Group's recommendations will be presented to the Council's Steering Committee and the Council in November 2009.

C. Incentive Alignment

The Council considered a wide range of options for modifying primary care practice payment and thereby realigning financial incentives. The framework recommended by the Council contained the following elements.

1. Payment should evolve over time towards a payment approach consistent with a system of global payment. The initial payment system should be a hybrid approach that build on the predominant fee-for-service payment system, but contain elements that must support movement to comprehensive payment and align with state-led efforts for broader payment reform.
2. Practices[12] should receive payment for start-up costs at the outset of the initiative. Examples of start-up costs for which the practices could possibly receive payment include compensation for time spent at learning collaborative sessions, practice registry software, and initial internal practice team planning meetings.
3. Practices should receive ongoing, supplemental payments for care management, population management, and other traditionally non-reimbursed activities, such as care team collaboration, that must be sustained for the PCMH model to be successful.
4. Practices should be provided with an opportunity for shared savings, with some linked to accountability for access and quality (process and outcome).
5. The payment design should consider the balance between fee-for-service payments and the new ongoing supplemental payments, and possibly reduce the amount of the fee-for-service payments, transferring the value to the supplemental payment as a means to a) realign incentives away from volume-driven care, and b) begin the transition to comprehensive payment.

Acknowledging the significant attendant challenges, the Council recommended consideration of possible risk adjustment of supplemental payments that include health and socioeconomic factors, and to consider differences in populations when setting performance metrics related to shared savings. The Council also recommended that efforts at incentive realignment should be pursued in coordination with ongoing state-led efforts for broader payment reform.

[12] For purposes of this document, a practice is a primary care practice *site*. The site may be a freestanding corporate entity, or part of a larger organization. It may also contract directly with payers, or through a larger entity with which it has a relationship, such as an independent practice association (IPA), integrated delivery system, or multi-site group practice.

D. Evaluation

EOHHS will fund the University of Massachusetts Medical School, Commonwealth Medicine (UMMS) to conduct the initial evaluation of the PCMHI. The Council considered and recommended for adoption an evaluation framework developed by UMMS. The evaluation framework components could be as follows:

1. Proposed Evaluation Objective: Collect information on the activities, outputs and outcomes of the PCMHI to provide on-going assistance to stakeholders in assessing the value of the Initiative and improving its design.
2. Evaluation Principles
    a. Collaborate with stakeholders.
    b. Use both qualitative and quantitative evaluation methods.
    c. Include both formative (implementation process, challenges and barriers) and summative (outcomes) components.
    d. Include comparison groups, if possible.
    e. Minimize the data collection burden on practices and payers.
3. Two possible research questions are:
    a. To what extent do practices become Medical Homes, including the components practices begin with, what facilitates adoption, challenges and barriers to adoption, and the components practices value more and why?
    b. What are the initiative's outcomes/results, including clinical, patient experience, provider satisfaction, access, expenditures and utilization?
4. Evaluation phases are as follows:
    a. Start-up (baseline data)
    b. Data collection
    c. Analysis and reporting

The Council made the following suggestions to the UMMS-developed framework:

- predicate the ultimate evaluation framework on funding availability;
- utilize a uniform methodology for attributing patients to primary care practices;
- place additional measurement focus on tracking the activity of care coordinators and care managers and on evaluating their effectiveness, and
- provide interim results prior to the completion of the full evaluation to allow for early estimates of savings and quality improvements, and an assessment of the need for mid-course corrections.

The Council created an Evaluation Work Group to develop specific strategic recommendations for adoption as part of the PCMHI. The Evaluation Work Group will recommend an evaluation design that addresses the desired outcomes for the initial PCMHI implementation, including the desired outcomes for the participating practices, as defined on page 4.

E. Practice Recruitment

The Council recommended some limited parameters regarding practice participation in the PCMHI.

1. Selection criteria should be designed such that participating practices are, collectively, generally representative of primary care practices in Massachusetts, including practices located in academic medical centers, community health centers, and independent community-based practices. Further work remains to be done to develop a definition of "representative."
2. Nominations from communities for practice groups to participate in this initiative should be considered further by the Council. The community would include employers, hospitals, practices, government, etc. and could be part of application.
3. The total number of practice participants should be determined based on the final payment model and the financial commitment each payer is willing to make in support of the PCMHI and its participating practices.
4. Applicants should be required to meet a set of basic qualifications that indicate that the practice should be able to succeed in medical home transformation as a result of its participation in the PCMHI.

Finally, because of the nature of EOHHS' role in the PCMHI, it will be necessary for all participating practices to be either a MassHealth participating provider or a contracted provider of a MassHealth managed care organization.

F. Payer Participation

The Council discussed the nature of payer participation. It did not attempt to formalize advice on such parameters, however. The Council was presented with the following recommendations by its consultant:

- All insurers with significant market share in the Massachusetts commercial health insurance and Medicaid managed care markets should participate.
- In order to ensure the adequacy of supplemental practice payments, commercial insurers should participate for *all* lines of business, including:
    - fully insured and self-insured business;
    - commercial HMO, POS, PPO, and indemnity business (including consumer-directed health plan products);
    - Medicare Advantage business, and
    - Medicare Private Fee-for-Service business.
- MassHealth should participate through its Primary Care Clinician (PCC) Plan. Patients dually eligible for Medicare and Medicaid should be excluded, at least until Medicare becomes a confirmed participant, since "dual eligibles" generally have their primary care benefits provided through Medicare.

- The state should pursue Medicare participation.[13]

G. Role of the Executive Office of Health and Human Services

The Executive Office of Health and Human Services initially convened the parties who constitute the PCMHI Council. EOHHS will provide ongoing oversight to support this community of practices, payers and other parties as they come together to design and launch the PCMHI.

EOHHS has the legal authority to assume this oversight role, and specific responsibilities that it must carry out as part of that role. The role is not dissimilar to that played by state government entities in Pennsylvania, Rhode Island and Vermont, where the state has played a crucial role facilitating the implementation of multi-payer medical home initiatives.

Because EOHHS is also responsible for the operation of the state's Medicaid program, MassHealth, it will participate in an oversight role, as a payer (for its directly administered PCC Plan) and as a purchaser (for its capitated managed care contracts).

H. Timeframe

In order to advance progress towards achieving the vision set forth by the Secretary and further developed through Council discussions, the PCMHI should pursue initial implementation in accordance with the following schedule of events:

1. Steering Committee develops detailed recommendations for PCMHI implementation and presents them to the Council for consideration (late fall 2009 through early winter 2010)
2. EOHHS drafts a participation agreement for use by participating payers and primary care practices, informed by Steering Committee and Council recommendations (early winter 2010)
3. Request for application document distributed to Massachusetts primary care practices (late winter 2010)
4. Practices selected (early spring 2010)
5. Participating practices and providers execute participation agreement and return to EOHHS (spring 2010)
6. Practices undertake pre-work for the learning collaborative, populate registries and/or develop required reports (spring through summer 2010)
7. First learning collaborative session (September 2010)
8. Subsequent learning collaborative sessions occur quarterly over the next 12 months

[13] The September, 2009 announcement by HHS Secretary Sebelius that the federal government would be soliciting state proposals to have Medicare participate in multi-payer "Advanced Primary Care" initiatives created such an opportunity for Massachusetts.

9. Assessment of early impact and evaluation of plan for continuation (February 2012)
10. Conclusion of initial implementation phase (August 2012)

III. Conclusion

There is a pressing need to transform primary care in Massachusetts, regardless of what other reform changes may occur in the broader environment. Such transformation can support an overtaxed and shrinking group of providers who serve as the foundation of the health care delivery system. Further, there is growing evidence that transforming primary care into a medical home model improves access, quality, and patient experience, and reduces costs. Finally, if the vision of the Special Commission on the Health Care Payment System is to be realized, it will require a base of Patient-Centered Medical Homes.[14]

Experience is showing that PCMH initiatives cannot succeed unless there is broad participation by major payers, and the specific design and implementation of the initiative is performed in a thoughtful manner. The initial work of the Council has positioned Massachusetts to realize a significant opportunity for improving Massachusetts health care.

[14] "Recommendations of the Special Commission on the Health Care Payment System" Massachusetts Special Commission on the Health Care Payment System", July 16, 2009.

APPENDIX A

General Functional Definitions of Care Coordination and Care Management Services
(adapted from definitions developed by Ed Wagner, MD[15])

Care Coordination

A core function of primary care and PCMHs is the delivery of a set of care coordination activities, assuring that patients receive timely, high quality and efficient health care and support services within and outside of the medical home through the development and implementation of a care plan and development of patient self-management skills. Services may be identified either by the practice by referral or by the patient or other providers to maintain or improve the well being of the patient and includes institutional services, clinical services and clinical and non-clinical support services available within the community. To coordinate care effectively, this role involves activities to:

- identify available community resources,
- assure that referrals made by the practice for external services result in timely appointments, timely two-way transmission of useful patient information, and address patient and practice concerns without duplication of services or provision of inappropriate services.
- obtain reliable and timely information about external services not initiated by the practice such as emergency, patient-initiated, or other provider-initiated care, as well as case management in order to provide and receive patient information, and to assure safe and effective transitions.
- interface with case management or disease management staff functioning on behalf of insurers, disease management companies, publicly funded programs, etc. to assure that services are consistent with the PCMH's care plan.

Clinical Care Management

The Clinical Care Manager has several unique functions, some of which can only be performed by a Registered Nurse. The unique activities of the clinical care management role are the identification of high-risk patients, and their more intensive monitoring, follow-up, and clinical management. These activities generally include

- frequent patient contact,
- clinical assessment,
- medication review and reconciliation
- communication with treating clinicians
- medication adjustment by protocol

Self-management support is also a critical element in this role. While care managers often take on some of the activities described in the care coordination role, especially related to transitions, their role is primarily clinical rather than administrative. The Clinical Care Manager can reside within the practice setting or be a part of a

[15] Personal communications with Judith Schaefer, MacColl Institute, September 2009.

community-based agency. In either situation, the Clinical Care Manager must be closely integrated within the practice primary care team.

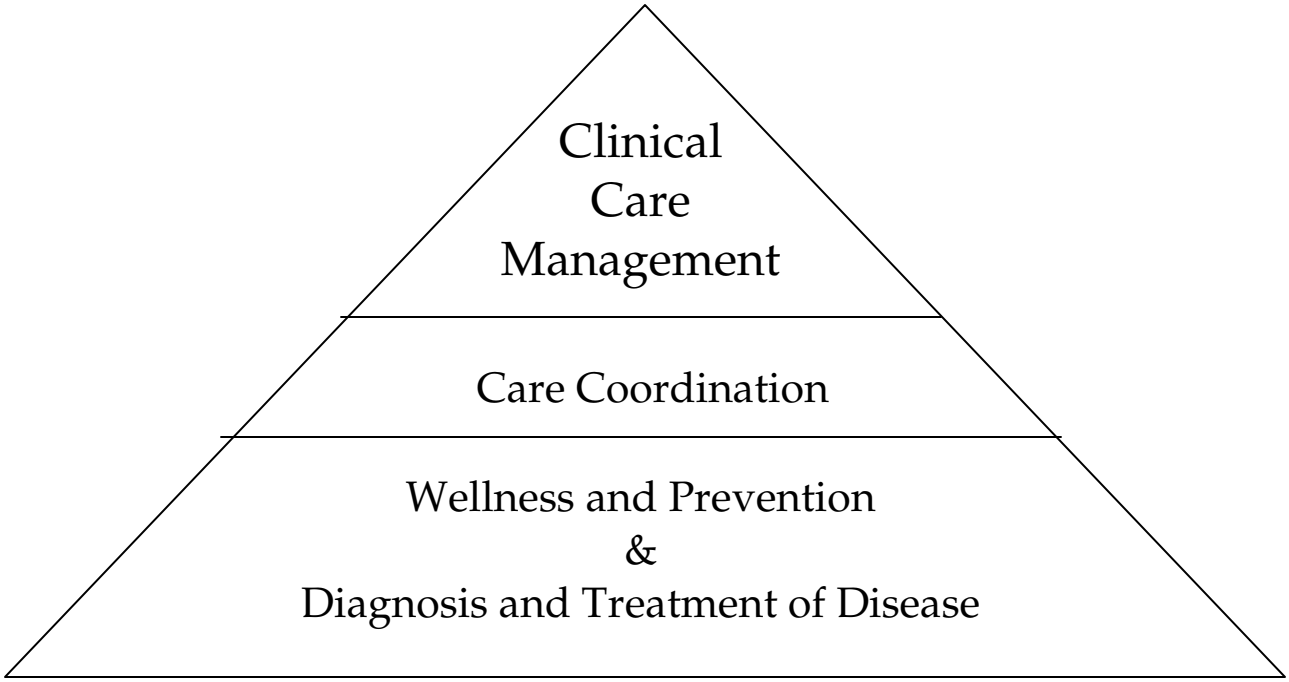
Note: The terms "Case Management" and "Disease Management" were consciously not used, because both terms are so closely linked to payer-based functions and as such differ from the practice-based functions described here. In addition, Case Management is a term that has specific meanings within several publicly funded health and human service programs. If successfully implemented and operated within the practice setting, Care Coordination and Care Management have the potential for eliminating the need for at least some public and private payer-based Case Management and Disease Management functions once practices are capable of assuming some or all of these responsibilities.

Patients in Need of Care Coordination and Clinical Care Management

	Patients Who Need Care Coordination	Patients Who Need Clinical Care Management
Description	Patient or family with low to moderate level of self-actualization who has a current medical condition and/or risk factors needing services or is healthy, but in need of services to prevent diminution of health status.	Patient with complex condition or multiple co-morbidities that places him or her at high risk for a future inpatient medical or behavioral health admission.
Duration of Services	Temporary, intermittent, or on-going, depending on nature of need	On-going until sufficient reduction in risk
Examples	45-year old patient recently diagnosed with cancer who is going to be laid off in 2 weeks and cannot afford COBRA 8-year old recently diagnosed with autism who needs educational, social, behavioral health and family support	Patient with uncontrolled diabetes
Provider Type	May be provided by trained layperson (parent, family advocate, community health worker), MA, NP, PA, MSW or RN	Must be provided by an RN
Goal of Services	Goal: to take action to assist the patient to remain as healthy as possible by accessing culturally appropriate and necessary care and community-based services and by using services appropriately.	Goal: to take action to keep the person safely cared for within the patient-centered medical home or across a system of care or community, preventing ER visits and hospitalization.

	Patients Who Need Care Coordination	Patients Who Need Clinical Care Management
Focus of Services	Broadly focusing on medical, psychosocial, educational needs and providing linkage to community services	Primarily a medical focus
Relationship to Medical Home	Physically or virtually located within the practice. Care Coordinator is a member of the PCMH care team.*	Physically or virtually located within the practice. Clinical Care Manager is a member of the PCMH care team.*
Key Service Functions	○ Care Coordination and follow-up ○ Development of multi-disciplinary care plan, created jointly by the individual or family and the care team, and which the individual or family has access to at all times ○ Support/facilitate care transitions ○ Provides linkages to needed community-based services, e.g., behavioral health services ○ Maintain continuous communication and documentation to assure care team's knowledge of activities/decisions/issues ○ Manage/track tests, referrals and outcomes ○ Assist patient/family with identifying barriers and problem solving solutions ○ Function as system navigator ○ Coach patients/families on self-management skills ○ Participate in QI activities at the level of the PCMH or broader system of care	○ Coordinates care among providers and across continuum of care ○ Population Management – identifies high risk patients in need of care management and pro-active outreach ○ Intense medical and medication management ○ Intense transition management ○ Care review and planning: ○ Complete/analyze medical, biopsychosocial support and self-management support assessments; ○ Update as necessary ○ Develops and maintains care plan ○ Provides Care Coordination services to patients receiving Clinical Care Management ○ Oversees care coordination activities delegated to other team members ○ Trains team members in care coordination and self-management support

*Smaller practices might share resources, which could be either dedicated resources or contracted resources from a community agency, such as a home care agency or Aging Services Access Point (ASAP).



Application of Care Management and Care Coordination by Population